OPERATIONAL PLAN

SIM Initiatives ($ millions)	Yr 1	Yr 2	Yr 3	Yr 4	Total
Plan for Improving Population Health	1.0	1.7	1.7	1.8	**6.2**
Care Delivery / Payment Reform	3.3	6.3	5.7	5.2	**20.5**
A. Medicaid QISSP	*2.4*	*1.7*	*2.8*	*1.0*	*7.9*
B. AMH Glide Path	*0.6*	*3.2*	*1.4*	*2.8*	*8.0*
C. Clinical Community Integration - TTA	*0.4*	*1.4*	*1.4*	*1.4*	*4.6*
Quality Alignment	-	0.3	0.3	-	**0.6**
A. Care Experience	-	*0.3*	*0.3*	-	*0.6*
Health Information Technology	1.3	3.6	3.6	2.3	**10.8**
Workforce Development	0.2	0.3	0.3	0.3	**1.0**
A. Community Health Worker	*0.2*	*0.3*	*0.3*	*0.3*	*1.0*
Value-based Insurance Design	0.2	0.0	0.0	0.0	**0.3**
Consumer Engagement	0.1	0.1	0.1	0.1	**0.4**
Program Evaluation	0.7	0.7	0.7	0.7	**2.7**
PMO Administration	0.4	0.6	0.7	0.7	**2.4**

Plan for Improving Population Health		
Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q1**: Establish Population Health Council. **Q2**: Produce comprehensive state-wide assessment.**Q3**: Identify public health priorities based on criteria of burden and cost; Conduct root cause and barrier analyses for tobacco, obesity and diabetes and other priority areas.**Q3-4**: Research evidence-based interventions for identified priorities; Analyze appropriateness and adoptability of interventions. Conduct trend analysis and set improvement targets for identified areas.**Q4**: Identify environmental, policy, systems changes, and/or community-clinical linkages and/or health systems interventions; facilitate coordination with ongoing public health initiatives. **Q3-4:** convene stakeholders.	*Priorities, Barriers, and Interventions Identified*
2	**Q1-3**: Conduct statewide scan to identify entities capable of providing evidence-based community-prevention services in the identified priority areas.**Q2**: Identify most appropriate funding options and federal authority to support community preventive services related to tobacco, obesity, diabetes and other identified priority areas. **Q2-3**: Identify highest burden of disease with local willingness and capacity to implement PSCs; Establish core HEC planning team and principles; Develop HEC MOA for DPH, DSS, PMO; Develop coordinated community and social service care model; Identify candidate HEC communities. **Q3-4**: Convene stakeholders.	*Pop Health Assessment Completed*
3	**Q1-2**: Convene organizations interested in providing PSC services; Finalize PSC selection of 2-3 demonstration sites; Develop formal agreements with lead organizations. Finalize PSC service menu. **Q2-4**: Promote PSC FQHCs and Advanced Networks; Facilitate development of formal agreements between primary care sites and PSCs.	*PSC Plan Complete*
4	**Q1-4**: Implement PSC demonstration; **Q2-4**: Develop detailed design of HEC model for Year 5 implementation.	*Final Plan*
Timeline assumptions, risks, mitigation of risk: Continued stakeholder engagement and		

interest; availability of cost data; interest and capacity in PSCs and HECs; length of time to hire. **Sustainability plan:** Engage private and public payers for sustainable financing of PSCs. For HEC, design and establish reserve fund/wellness trust based on expected savings or other sustainable financing mechanism.
Key Personnel: *DPH Physician 2* will lead all aspects of the DPH-based SIM work to develop and advance a cohesive, unified public health approach including integration of population health and health equity and completion of planned activities. *William Halsey, Director of Integrated Care,* will lead all aspects of the DSS-based unified public health approach.

Primary Care Transformation and Medicaid QISSP

Our three-part Primary Care Transformation initiatives will be targeted to those providers and beneficiaries that are participating in the Medicaid QISSP. The table below provides a cumulative summary of providers projected to enroll in Waves 1 and 2 and the projected number of beneficiaries that will be directly affected by this targeted component of our Model Test.

Year/Quarter		Comm/Medicare Beneficiaries	Medicaid Beneficiaries**	FQHCs	Advanced Networks*
Year 2	Q1-4	505,000	205,000	10	3
Year 3	Q1-2	505,000	209,000	10	3
	Q3-4	1,510,000	209,000	14	12
Year 4	Q1-4	1,510,000	429,000	14	12

*Many or most include one or more hospitals

**Note that more than 600,000 Medicaid beneficiaries are expected to participate in the Medicaid QISSP by 2020, consequent to a third wave of provider enrollments.

Medicaid Quality Improvement and Shared Savings Plan (Medicaid QISSP)		
Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q1-2**: Determine model requirements, begin program design, evaluation and actuarial support; Hire staff to review claims and examine patterns of provider behavior via LexisNexis Intelligent Investigator™ software. **Q2-3**: Conduct assessment to determine the sufficiency of PCMH payments; Develop Wave 1 RFP for FQHC and advanced network provider entry. **Q2-4**: Develop SSP for Medicaid; With Equity and Access Council, develop methods to identify under-service. **Q3**: Conduct clinical staff translation of criteria into appropriate service codes to run investigative software; Prepare baseline reports for comparison of utilization changes occurring after the implementation of the SIM program for Medicaid beneficiaries; Procure providers: **Q4:** Complete assessment of provider compatibility; Develop & execute provider contracts with common performance measures, upside only SSP agreement, reporting requirements to SIM data aggregator and population health management entity; Commence on-going staff training and transition of post-implementation and sustainability responsibilities; Commence on-going TTA to providers.	*Progress to Plan*
2	**Q1-4**: Commence under-service monitoring, with detailed reporting and drill down analyses by provider, provider group and patient; Conduct provider site visits to review findings; Provide reports to PMO and Equity and Access Council; Coordinate evaluation and data reporting activities. **Q2:** Perform	*Progress to Plan*

	contract monitoring of participating providers; **Q3-4**: Aggregate data; Refresh contract language to update performance measures and SSP requirements.	
3	**Q1-2**: Develop Wave 2 RFP for provider entry; Develop provider contracts; **Q1-4**: Continue under-service monitoring; Coordinate evaluation and data reporting activities.**Q2**: Perform contract monitoring on Wave 1 participating providers; Procure Wave 2 providers; **Q3-4**: Aggregate data; Refresh contract language to update performance measures and shared saving program requirements.	*Progress to Plan*
4	**Q1-4:** Continue under-service monitoring; **Q3-4:** Aggregate data; Coordinate evaluation and data reporting activities.	*Progress to Plan*

Timeline assumptions, risks, mitigation of risk: Assumes Wave 1 enrollment 200,000 beneficiaries into SSP. Risk of insufficient participation mitigated by stakeholder engagement and CQI; perceived risk of under-service mitigated by reporting, monitoring, and Office of Healthcare Advocate Nurse Consultant. **Sustainability Plan:** Funding of ongoing program costs sustained by shared savings. **Key Personnel:** *William Halsey, DSS Director of Integrated Care,* with extensive large program implementation, will provider overall direction for Medicaid QISSP.

Advanced Medical Home (AMH) Glide Path

Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q1**: Establish milestones and standards for AMH; develop and release RFP for transformation support vendors and learning collaborative (LC) vendors; **Q2**: Select vendors; **Q3**: Create milestone pathway and metrics to track progress on path. Enroll practices from Advanced Networks for Wave 1. **Q4**: Begin ramp-up of AMH Glide Path (GP) and LC.	*Vendor Contracts; #Providers; #FQHCs; #Advanced Networks; # practices; #LC participants; #LC activities*
2	**Q1-Q4**: Ongoing enrollment; monthly conference calls; LC webinars; quarterly SME presentations; continuous LC webpage updates & milestone reporting. **Q2:** End Wave 1 enrollment.	*Same as Year 1*
3	**Q1-Q2:** Finalize Wave 1. **Q2**: 185 practices transformed to AMH status. Begin recruiting Wave 2 practices. **Q3**: Wave 2 begins with new practices. **Q3-Q4**: Monthly conference calls; LC webinars; quarterly SME presentations; continuous LC webpage updates & milestone reporting.	*Same as Year 2*
4	**Q1-Q4**: Ongoing enrollment of practices; monthly conference calls; LC webinars; quarterly SME presentations; continuous LC webpage updates & milestone reporting. **Q4**: 370 practices transformed to AMH status.	*Same as Year 3*

Timeline assumptions, risks, mitigation of risk: AMH Glide Path (GP) and LC will be delivered in two 18 month waves; each with 185 practices; slow adoption and ramp up in year 1; mitigation of slow practice progress through continuous milestone reporting and tracking with red flags transformation support. **Sustainability plan:** Sunset at end of grant period.

Key Personnel: The PMO *Primary Care Transformation Manager* will oversee the AMH Glide Path and LC program implementation and will procure and manage vendors with expertise and experience with primary care transformation and medical homes.

Community and Clinical Integration Program (CCIP) – Targeted Technical Assistance/LC

Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q1**: Procure TTA/LC vendor; **Q2**: Develop TTA implementation	*Vendor contract; LC*

	guide/milestones and LC program for 9 TTA topics; **Q3:** Enroll providers; **Q4**: Roll out Wave 1 TTA/LC with monthly webinars and quarterly workshop.	*schedule; # provider, staff enrolled; #/type attendees;# evals*
2	**Q1**: 6-month survey of Wave 1 TTA/LC participants; **Q1-4**: On-going TTA/LC with monthly webinars and quarterly workshop; **Q3**: 12-month survey of Wave 1 TTA/LC participants.	*Same as Year1; Survey Summary*
3	**Q1**: Final survey of Wave 1 TTA/LC participants; Wave 1 TTA/LC program evaluation; **Q2:** Enroll Wave 2 providers; **Q3-Q4**: Start Wave 2 TTA/LC with monthly webinars and quarterly workshop; **Q4**: 6-month survey of Wave 2 TTA/LC participants.	*Same as Year 2*
4	**Q2:** 12-month survey of Wave 2 TTA/LC participants; **Q1-3**: On-going TTA/LC with monthly webinars and quarterly workshop; **Q4**: Final survey of Wave 2 TTA/LC participants; **Q4**: Final program report/evaluation.	*Same as Year 3; final report on TTA/LC program*
Timeline assumptions, risks, mitigation of risk: TTA/LC will be offered in two 18-month waves; slow or unbalanced provider and practice staff enrollment mitigated by working closely with leadership of Advanced Networks and FQHCs to optimize and balance practice and participant enrollment. **Sustainability plan**: Initiative will sunset at end of grant period.		
Key Personnel: PMO *Primary Care Transformation Manager* will procure, contract, and manage a vendor that has experience and expertise in care delivery TTA/LC.		
Quality Alignment - Care Experience Survey		
Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q1**: RFP for vendor to deliver care experience survey tool. **Q2**: Quality Council selection and Steering Committee approval of survey tool. **Q3**: Selection of care experience survey vendor.	*Selection of survey; Selection of vendor*
2-3	**Q1**: Identify attributed members, sampling frame; Conduct care experience survey. **Q2-Q4**: Analysis & reporting of results to health plans for SSP calculations. **Q3:** Establish survey fee collection procedures; **Q4:** Collect survey fees	*#surveys; #reports*
4	**Q1**: Identify attributed members, sampling frame; Conduct care experience survey. **Q2-Q4**: Analysis & reporting of results to health plans for SSP calculations. **Q4:** Collect survey fees	*#surveys; #reports*
Timeline assumptions, risks, mitigation of risk: Assumes survey vendor is selected in Year 1, 3 survey waves, the 1st establishing a baseline. Attribution conflicts could delay; pre-establish attribution policy. **Sustainability plan**: Transfer cost to Advanced Networks/FQHCs Year 3.		
Key Personnel: PMO Health Program Associate coordinates progress to plan for performance scorecard development and implementation, supervision by Director, Healthcare Innovation.		
Quality Measure Alignment - Common Performance Scorecard		
Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q1-2:** Multi-stakeholder review of Quality Council recommendations for primary care performance scorecard measures and payer SSP calculation methods, cross-payer performance analytics, reporting frequency, and consumer transparency; Develop multi-stakeholder implementation plan; Payer meetings, align on timeline. **Q2-4:** Payers modify systems; Begin DSS HIT/analytics design and programming for provider-	*Scorecard & process specs established; Quality Council; # payers implementing common scorecard; # PCP contracts with common scorecard*

	specific cross-payer performance analytics; develop infrastructure to disseminate the scorecard; **Q1-Q4:** Quality Council develops common performance scorecard measures for selected specialists. **Q3-4:** Quality Council establishes plan for consumer education and access to scorecard data; Complete payer systems modifications.	*requirements*
2	**Q1-4**: Launch common performance scorecard across all payers; roll-out consumer education plan; aggregated analytics for PMO evaluation; review scorecard utilization data; convene monthly Quality Council meetings. **Q2-3**: refine processes to identify care and quality gaps; Payers modify systems for specialist scorecards; Quality Council develops common performance scorecard measures for additional specialists and hospitals; **Q2-4**: review performance scorecard analytics and identify care gaps for rapid-cycle refinement; **Q3-4**: incorporate new national measures to keep pace with best practices.	*Quality Council; # payers implementing common scorecard; # PCP contracts with common scorecard requirements; # reviews to common scorecard based on identified care gaps*
3	**Q1-4**: review common scorecard analytics and identify care gaps for rapid-cycle refinement; incorporate new national measures to keep pace with clinical and technological practice; convene bi-monthly Quality Council meetings. **Q2-4:** Payers modify systems to include specialist and hospital scorecards; DSS HIT/analytics design and programming for cross-payer performance analytics;	*Same as year 2*
4	**Q1**: Launch specialist and hospital common performance scorecard. **Q1-4**: Review common scorecard analytics and identify care gaps for rapid-cycle refinement; incorporate new national measures to keep pace with clinical and technological practice; convene quarterly Quality Council meetings.	*Implement specialist, hospital scorecard; Same as year 3*
Timeline assumptions, risks, mitigation of risk: Quality Council develops initial scorecard recommendations by Q1 2015; payer production costs and delays with scorecard production; mitigated by early health plan and HIT engagement. **Sustainability plan**: Payer adoption of a common scorecard; PMO funded Quality Council oversight and refinements.		
Key Personnel: PMO *Research Analyst* coordinates progress to plan for performance scorecard development and implementation.		
Health Information Technology		
Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q1**: Hire staff; establish HIT Council; Procure Consent Registry & edge Servers; **Q1-Q2:** Amend existing contracts for APCD, Master Patient Index, Provider Directory, Direct Messaging; **Q1-3:** Develop 3-yr HIT Strategic Plan including SIM HIT/Analytics requirements. **Q2-3**: Procure new systems – re-purpose Quality Reporting Document Architecture for receiving eClinical Quality Measures to collect core quality measures data; assist PMO to coordinate DURSAs with data owners; **Q3-4:** Procure new systems – Disease Registry; EHR (SaaS); Provide DM addresses to providers; Commence cross-payer analytics, including common performance scorecard; Commence technical assistance for providers.	*Progress to Plan*
2	**Q1:** Procure mobile care management apps via crowd sourcing; **Q1-4**: Continue	*Progress*

	providing technical support to practices; continue to produce cross-payer analytics; continue to convene HIT Council, continue to operate the HIT assets in an optimized manner, continue to work with targeted stakeholders to identify new needs as the status of HIT acquisition and operations changes.	*to Plan*
3	**Q1-4**: Continue providing technical support to practices; continue to produce cross-payer analytics; continue to convene HIT Council, continue to operate the HIT assets in an optimized manner, Continue to work with targeted stakeholders to identify new needs as the status of HIT acquisition and operations changes over the test period.	*Progress to Plan*
4	**Q1-4**: Continue providing technical support to practices; continue to produce cross-payer analytics. Continue to convene HIT Council, continue to operate the HIT assets in an optimized manner; continue to work with targeted stakeholders to identify new needs as the status of HIT acquisition and operations changes over the test period. Refresh 3-yr HIT Strategic Plan.	*Progress to Plan*

Timeline assumptions, risks, mitigation of risk: Risks to the timeline associated with dependencies that all payers and providers are ready to launch technologies and allow indexing. Assume adjustments will be needed to timeline, early engagement of providers/health plans. **Sustainability plan:** Ongoing HIT operational expenses distributed between the state, Medicaid, and private payers. HIT Council will assist in identifying and creating sustainability plans.

Key Personnel: *Minakshi Tikoo,* HIT Coordinator and Director Business Intelligence & Shared Analytics, will be responsible for providing oversight for the overall staffing, organization, coordination and implementation of the HIT solutions and technical assistance. Dr. Tikoo has served in this role for two years and has considerable experience in implementing and evaluating HIT-based CQI, research and evaluation.

Workforce Development – Community Health Worker (CHW)

Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q 3-4**: Engage CHW leaders/organizations; support development/expansion of CHW Association for strategic planning, marketing support and product development; CHW workforce needs assessment; recruit trainees for 1st CHW class.	*Needs assessment, # trainee applications*
2	**Q1-2**: Develop training curriculum, certification program; **Q1-4:** Identify internship sites; Provide training to 25 CHWs. **Q2-4**: Coordinate Boot Camp credit bearing curriculum. **Q3-4**: Develop Advisory Board for policy development and facilitate discussions about CHW sustainability models.	*Curriculum specs; # training sites; # certificates earned; Advisory Board minutes/policies*
3	**Q1-4:** Expand program to 35 CHWs; Hold annual conference.	*# total certified; # conference attendees*
4	**Q1-4**: Expand CHW training program to 40 CHWs; Evaluate program; CHW curriculum review and delivery; facilitate stakeholder planner meetings; produce white paper on CHW sustainability post SIM funding; facilitate annual conference.	*Same as Year 3 Sustainability model white paper*

Timeline assumptions, risks, mitigation of risk: Re-engineering practice and financing CHWs as team members mitigated by establishing as priority are for team-based care TTA; employer market research early in SIM timeframe. **Sustainability plan**: CHW career ladder development; employer based support for CHW training.

Key Personnel: *Bruce Gould, MD, FACP*: Associate Dean for Primary Care, Director, CT

AHEC, UConn School of Medicine will initiate multi-stakeholder CHW workforce development activities; *Meredith Ferraro, MS,* Executive Director Southwest AHEC, will serve as a contractor for the CHW workforce training program; has extensive knowledge of CHW training and deployment; is engaged in regional/national CHW workforce development workgroups.

Employer Engagement - VBID Acceleration

Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q1**: Conduct baseline survey; issue RFP for VBID consortium and learning collaborative facilitator; start VBID/ACO actuarial evaluation study. **Q2**: Convene VBID consortium, develop VBID templates and toolkit. **Q3**: Launch employer portal on SIM website. **Q4**: Plan 1st statewide VBID learning collaborative.	Progress to plan, # employers engaged
2	**Q1**: Convene 1st VBID learning collaborative; Access Health CT implements VBID. **Q1-4:** Continue VBID/ACO study. **Q2**: 1st pilot.	44% VBID adoption in commercial
3	**Q1**: Convene 2nd VBID learning collaborative**. Q1-4:** Continue VBID/ACO study. **Q2**: 2nd pilot. **Q3**: Evaluate performance of 1st pilot; **Q4:** VBID/ACO study report of findings.	53% VBID adoption in commercial
4	**Q1:** Convene third VBID learning collaborative**;** present VBID/ACO study findings. **Q2**: Third pilot of employers/employees. **Q3**: Evaluate performance of 1st and 2nd pilots.	65% VBID adoption in commercial

Timeline assumptions, risks, mitigation of risk: Assume employer engagement, supporting regulatory levers, Access Health CT board approval. **Sustainability plan:** This initiative will sunset at the end of the grant period.

Key Personnel: *Thomas Woodruff,* PhD, is Director of the Healthcare Policy & Benefit Services Division of the Office of the Connecticut State Comptroller (OSC) and lead advisor on the VBID initiative. OSC is responsible for administration of the state's employee and benefit programs for 210,000 employees.

Consumer Engagement

Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q1:** Establish consumer portal on SIM website; establish communication infrastructure for CAB/ PMO consumer engagement; CAB quarterly public meetings and monthly workgroup meetings; **Q2**: Outreach and education; begin ongoing targeted communications and quarterly virtual LC.	*Progress to Plan*
2	**Q1-4:** CAB quarterly public meetings and monthly workgroup meetings; outreach and education; Ongoing targeted communications and quarterly virtual LC; Issue driven focus groups and listening tours.	*# consumers engaged*
3	**Q1-4:** CAB quarterly public support meetings and monthly workgroup meetings; outreach and education; Ongoing targeted communications and quarterly virtual LC; issue driven focus groups/ listening tours.	*# consumers engaged*
4	**Q1-4:** CAB quarterly public support meetings and monthly workgroup meetings; outreach and education; Ongoing targeted communications and quarterly virtual LC; issue driven focus groups and listening tours.	*# consumers engaged*

Timeline assumptions, risks, mitigation of risk: Assumes substantial interest, engagement, and participation of voluntary board members; risk of continuity mitigated by development of continuity plan. **Sustainability plan:** This initiative will sunset at the end of the grant period.

Key Personnel: *Durational Project Manager B* will provide oversight for consumer engagement activities for the SIM PMO. The *Program Coordinator (Contractor)* will provide coordination support for the Consumer Advisory Board.

Program Evaluation

Yr	*Quarterly Activities/Milestones*	*Metrics*
1	**Q1**: Establish and commence Rapid Response Team; Develop core dashboard measures to monitor changes in cost, quality, outcomes and program pace and facilitate rapid-cycle evaluation; develop MOAs and informatics platform to support ongoing acquisition and storage of data from, APCD, OSC; Determine CMMI evaluator requirements and measures. **Q2:** Develop RFP for data collection vendor. **Q3**: Analyze APCD data to establish baselines and populate cost, quality, and outcomes dashboard. **Q4:** Update cost, quality, and outcomes dashboard; compile or collect care experience survey data to establish statewide baseline.	*Dashboard measures; MOAs; Contract with vendor for survey data collection; CMMI Reporting*
2	**Q1-4:** Produce pace dashboards and quarterly cost, quality, outcomes dashboards using APCD data; Obtain data from payers regarding physician participation in FFS and SSP, beneficiaries in VBID; **Q2:** Analyze data from Year 1 care experience survey; Update quarterly data on hospitalizations for ACSCs using 2015 data; **Q3**: Develop scope for survey of physicians to examine changes in practice patterns and care delivery; RFP for data collection vendor.	*Vendor Contract; Published dashboards; CMMI Reporting*
3	**Q1-4:** Produce quarterly cost, quality, outcomes and SIM program pace dashboards using APCD data; Obtain data from payers regarding physician participation in FFS and SSP, beneficiaries in VBID. **Q2**: Analyze data from Year 2 physician survey; **Q3**: Update data on hospitalizations for ACSCs using 2016 data.	*Published dashboards; CMMI Reporting*
4	**Q1-4:** Produce quarterly cost, quality, outcomes and SIM program pace dashboards using APCD data; obtain data from payers regarding physician participation in FFS, shared savings, and global payment arrangements **Q3:** Update data on hospitalizations for ACSCs using 2017 data. **Q4**: Finalize evaluation report.	*Published dashboards* *CMMI Reporting*

Timeline assumptions, risks, mitigation of risk: Key risk to timeline is deployment of APCD by Q1 2015. Risk mitigated in part by the availability of all payer hospital data from DPH's HIDD & payer willingness to share measure data as an interim or rapid cycle strategy. **Key Personnel:** *Robert Aseltine*, PhD, is Deputy Director of the Center for Public Health and Health Policy at UCHC. Dr. Aseltine will be responsible for SIM Program Evaluation. He will collaborate with *Paul Cleary*, PhD, Dean of the Yale School of Public Health and nationally recognized expert in patient surveys.

Program Management Office (PMO)

Mark Schaefer, PhD, Director of Healthcare Innovation is responsible for the overall direction of SIM initiatives. Dr. Schaefer has 13 years experience in Medicaid administration, four years as Medicaid Director, including development, implementation, and oversight of major program and reimbursement reforms. Eight additional full time PMO staff will provide in-kind support.

Governor and State Agency Involvement

Governor Dannel P. Malloy is deeply committed to care delivery and payment reform and the initiatives proposed as part of our Model Test. Lieutenant Governor Nancy Wyman, who chairs the Healthcare Cabinet and Connecticut Health Insurance Exchange Board, heads the SIM Steering Committee. Commissioners of the Departments of Public Health, Social Services, Children and Families, Mental Health and Addiction Services, and the Healthcare Advocate, and other agency officials are committed to the successful execution of our Model Test.